PLEASE PRINT IN BLUE OR BLACK INK ONLY

KC1100 Rev. 1/13

For Agency Use Only:

1. **Tell us about yourself:** If you are applying for children only, a parent, guardian or adult household member must be listed.

Legal Name: _____ List any other names used: _____

Home address: _____ Apt. or Lot #: _____ City: _____ County: _____ State: _____ Zip Code: _____

Mailing address (if different): _____ City: _____ State: _____ Zip Code: _____

Home #: (___)_____ Message/Cell phone #: (___)_____ Work #: (___)_____ Is it ok to call you at work? No ____Yes _____

2. **Tell us about everyone living in your home:** Start with yourself on line #1. Mark each person you want covered and provide their Social Security Number (SSN). Listing the SSN for everyone in your home may help us serve you better. Use a separate sheet of paper if you need more space.

Applying for		Legal Name (if pregnant, list "unborn child" on a separate line)	If pregnant, indicate expected due date	Relationship to Person #1	M F	Social Security Number	Date of Birth	U.S. Citizen?		State/ Cntry of Birth	Race/ Ethnicity (optional)	Full Name of Parents – Complete for persons under the age of 19, including unborn children	
Yes	No							Yes	No			Father	Mother (Maiden Name)
		1.		Self									
		2.											
		3.											
		4.											
		5.											
		6.											

3. **Tell us about your income:** Proof of all income, before deductions, is required. Examples include copies of pay stubs, a statement from your employer, benefit letter, etc. If you work for yourself (self-employed), you must provide your most recent complete tax return, if filed. A statement of income and expenses for the last three months for your business is required if you do not have a tax return.

Does anyone in your household have a job or is anyone self-employed? No _____ Yes _____ If yes, fill out the chart below for all jobs.

Name of Wage Earner	Company Name and Phone (if self-employed list type of business)	Salary or Hourly Wage	Tips, Commission, or Bonus	Hours Worked Weekly	How often do you get paid?	Day of the Week Paid	Date of Next Paycheck	For Self-Employed Persons Only	
								Monthly Income (Before Expenses)	Monthly Business Expenses

Does anyone in your household, including children, receive income such as child support, alimony, unemployment, Social Security/SSI, worker's compensation, veteran's benefits, etc.? No _____ Yes _____ If yes, fill out the chart below for each person receiving income.

Name of Person Receiving Income	Type/Source of Income	Amount Received (Before Deductions)	How Often Received	Claim/Court Order Number

4. **Does anyone you are applying for need help paying medical bills from the last 3 months? No _____ Yes _____**
If yes, you must provide proof of all income your family has received in each of the past 3 months.

5. Does anyone you are applying for have health insurance of any kind (other than Kansas medical assistance)? No _____ Yes _____ If yes, fill out the chart below and provide copies of all the insurance cards (both sides).
If health insurance has ended in the past eight months for anyone you are applying for, please explain why. _____

Name of Insurance	Policy Holder	Persons Covered	Type of Coverage (Hospital, Dental, Other)	Start Date	End Date	Policy Number & Group Number

6. If you pay someone to watch a family member while you work, how much do you pay per month? _____ This information is not used for all programs.

7. Does anyone in your household receive income from a trust fund? No _____ Yes _____ If we need more information, we will contact you.

8. Do you prefer a language other than English? No _____ Yes _____ If yes, please list. Written: _____ Spoken: _____

Do you use other media to communicate, such as sign language, Braille, TDD, other? No ____Yes ____ If yes, please list. Other Media: _____

9. Choose Your Health Plan: If approved for medical assistance, your services will be provided by KanCare. There are 3 KanCare health plans to choose from. Please review the Extra Services Highlights and choose your plan. If you do not choose, a plan will be assigned for you. If you do not like your assignment, you will have 90 days to change plans. You will receive a packet of information about your plan.

☐ Amerigroup ☐ Sunflower State Health Plan ☐ UnitedHealthcare

10. Important Conditions and Authorization to Release Information:

I understand:

- I have the right to equal treatment regardless of race, color, sex, age, disability, religion, political belief, or national origin.
- I have the right to have information I have provided kept confidential unless directly related to the administration of Kansas medical assistance programs.
- I have to provide or apply for a Social Security number for anyone who is applying for medical assistance and I authorize use of these numbers to administer the program. These numbers will also be used for computer matches with other organizations such as banks, the Social Security Administration, and Internal Revenue Service.
- It is important to provide current income, address, and household composition information, and I am responsible for reporting changes during the application process and while eligible.
- Some or all of the people for whom I am applying may receive similar health coverage under the Medicaid program if eligible. I have the responsibility to use and report any third-party resources (such as health insurance, court settlements, medical support payments, trusts, conservatorships, etc.) that may have a legal obligation to pay any or all of the medical expense of those for whom I am applying. I understand that payment for a particular service may be withheld while a determination of failure to use a third-party resource is made.
- Any payments made to me by a third-party resource for medical services covered under Kansas medical assistance programs will be used to pay for the applicable medical bills and that these programs will only pay for services not covered by that third-party resource. I agree to cooperate with the medical subrogation unit in pursuing those third-party resources.
- If I receive medical assistance after age 54 or while in an institutional arrangement, there may be a claim against my estate to recover the medical expenditures made on my behalf. I understand that my financial institution(s) will be notified of a pending claim.
- I have the responsibility to read and truthfully answer all the questions on this application. I understand that if I provide false or purposefully misleading information on this application or hide information requested by the application, I will be subject to penalties for my actions.
- I have the right to request a fair hearing if I disagree with a decision. A written request must be made within 30 days of the decision.

I agree:

- To turn over any medical support payments for all persons receiving medical assistance if adults in the household are determined eligible for medical assistance.
- To help Child Support Services (CSS) in establishing and enforcing support orders (if needed) if adults in the household are determined eligible for medical assistance.

I certify:

- That everyone I am requesting health coverage for – and who is determined eligible for such coverage – is a U.S. citizen or is a non-U.S. citizen in lawful immigration status. Proof of immigration status may be required. (Exception: persons applying for emergency medical assistance under SOBRA)
- Under penalty of perjury, that my answers are correct and complete to the best of my knowledge.

I authorize:

- Payments under this program to be made directly to the physicians and other medical providers on any medical and other health services furnished to those for whom I am applying while eligible.
- Medical providers to release medical information to the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE DHCF), the Department for Children and Families (DCF), the Kansas Department for Aging and Disability Services (KDADS), the U.S. Department of Health and Human Services, insurance companies, and other contracted medical providers. I also authorize KDHE, DCF, and KDADS to share medical information for administrative purposes with other agencies and contractors.

11. Signature: This application must be signed and dated in order to be considered a complete application.

_____
Signature of Applicant (Required) Date

_____
Signature of Spouse or Other Adult (If Applying) Date

My signature on this application signifies that I have read and understand the conditions above. It also authorizes employers, medical providers, financial institutions, insurance providers, benefit providers and other persons or agencies with knowledge of my circumstances to release to KDHE, DCF, KDADS, or other benefit programs any information, including confidential information, necessary to establish my eligibility. All information provided on this application is protected by state and federal confidentiality laws. This release is valid from this date. A copy of this authorization is as valid as the original.

12. Kansas Voter Registration Information: Would you like to register to vote today? No ____ Yes ____ Already Registered ____ This section will **not** affect your medical assistance.